reviews

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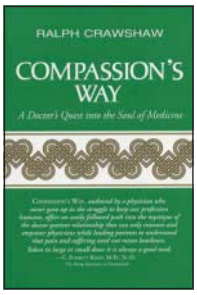
Compassion's Way: A Doctor's Quest into the Soul of Medicine

Ralph Crawshaw



Medi-Ed Press, $38.50, pp 648
www.Medi-Edpress.com/
ISBN 0 936741 15 5

Rating: ★★★★

What goes into the making of a good doctor? Most teachers and mentors stress intelligence and diligence. Yet they tend to ignore compassion, which is equally important. Ralph Crawshaw believes that our present medical education "leaves too many young people bereft of compassionate imagination and altruistic ideals."

Crawshaw—a psychiatrist, humanist, thinker, movie critic, knight errant, and world traveller—addresses both doctors and patients. The theme of his book is evident in the title. Yet Crawshaw's canvas is big and he touches upon topics as diverse as the movie *Gandhi*, undrained brains in the developing world, corruption, slavery, academic sanctions, and the Hippocratic oath and its variants. Many of the articles are reprints of pieces previously published in the *Journal of the American Medical Association*, *The Pharos* (for which he wrote a regular film review column for years), and other journals. Those that have dated have been published, with slight editing, to illustrate that the more things change the more they remain the same.

Crawshaw modestly suggests that we read a few pages of the book before starting the initial autobiographical essay, in order to decide whether it is worthwhile getting to know the author. He need have had no such worry. He speaks with passion and compassion, and his writing style is elegant and enviable.

I found his travelogues particularly magical. Crawshaw explores compassion in different cultures and societies and learns, for instance, that the closest Chinese and Russian equivalents are "revolutionary humanitarianism" and "co-suffering" (sostradanya) respectively.

The essay comparing the medical profession with the knights of the past is outstanding and reveals the deep learning and wide interests of this renaissance scholar. That knighthood was unable to survive is a lesson that we must learn from.

We meet many wise patients in this book, because physicians learn medicine on and from their patients. Crawshaw illustrates the importance of touch in strengthening the doctor-patient bond, which is something that I can vouch for from my own experience as a patient years ago.

The size of this tome and the philosophical nature of the essays meant that I could read only a few pages at a time. Doctors, especially those in training, will benefit greatly from the various pearls—the importance of punctuality, and respect for elders and those socio-economically less privileged—that are scattered throughout.

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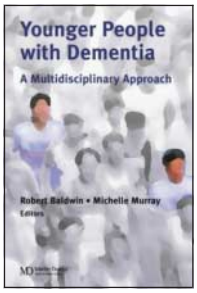
Younger People with Dementia: A Multidisciplinary Approach

Eds Robert Baldwin, Michelle Murray



Martin Dunitz, £39.95, pp 210
ISBN 1 84184 272 9

Rating: ★★

Early onset dementia destroys the mind, often at the peak of its powers. Families are devastated, and children feel cheated by an affected parent's loss of identity. In the face of what appears to be—paradoxically—good bodily health, a lifetime's accumulated experiences, knowledge, and sensible judgment are no longer accessible. Family and friends can see that expert assessment is essential but occasionally lacking. In the United Kingdom about 20 000 middle aged people with this disorder need investigation and support. Their needs are not always met. Families sometimes say that a healthcare system designed for old people with dementia fails to meet the needs of younger patients.

The driving force behind this book is a strong belief in the duty to care, easily likened to the huge improvements taking place in palliative medicine. The editors argue forcefully that access to specialist diagnostic services should be mandatory for all younger people with dementia. They effectively relate the skills and models of care derived from psychiatry of elderly people to the problems of younger patients with dementia but acknowledge that sometimes other models may be more appropriate.

Their development of a local service for early onset dementia is articulated with contributions from geriatric psychiatry, neurology, clinical psychology, social work, psychiatric nursing, family and group therapy, and support services. The authors explain how these disciplines integrate to form a comprehensive service. Each account is competently written, mostly in lecture note style, with many checklists and illustrative case summaries. The result is a readable educational resource—but this is not a textbook on early onset dementia. Several recent texts accomplish this task very well, such that this book is best seen as complementing those.

When the focus is care, there are several important omissions. Most telling is the failure to link diagnosis to prognosis. Less so is the lack of mention of recent improvements in nutritional care in dementia. The checklist approach to assessment and service provision will be helpful for people setting up services and training support staff. But efficient use of investigations, selective referral to specialist services, and audit require more sophistication. In most branches of medicine algorithms are available to guide clinical judgment. Where pathways through care and assessment are as intricate as the diverse pathologies underlying early onset dementia, a route map with signposts at critical crossroads would help the reader visualise the complex issues involved.

The book provides a practical approach to improved care. Young adults with dementia do not belong in geriatric psychiatry services, where they seem "old before their time." Mixing compassion with practical guidance, this book shows that other models of care are possible. Their efficacy remains an open question.

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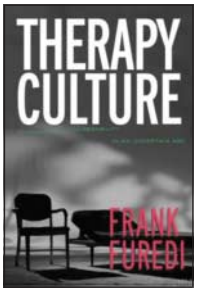
Therapy Culture: Cultivating Vulnerability in an Uncertain Age

Frank Furedi



Routledge, £16.99, pp 243
ISBN 0 415 32159 X

Rating: ★★★

Frank Furedi is professor of sociology at the University of Kent, Canterbury. He is also, perhaps, the nation's best known sociologist, partly as a result of popular books such as *Therapy Culture*, which has been extensively reviewed in the national press.

In *Therapy Culture* he argues that the language and sentiment of psychotherapy have now spread outside the confines of the clinic, widely infecting society at large. As a result emotional vulnerability has become the defining feature of people's psychology, leading to a "unique sense of powerlessness." Furedi questions the widely accepted thesis that psychotherapy as an ideology represents an enlightened shift towards emotions. But is it really the case that people didn't feel powerless before?

We do, however, live in apparently peculiar times. Tony Soprano, head of America's favourite television gangster family, goes to a therapist. American girl scouts can now get a badge in being stress free. And it is now possible to buy pet insurance packages that provide counselling for those whose pets have died.

Furedi also reports that an attempt to map the number of counselling encounters taking place in Britain in February 1999 concluded that there had been 1 231 000 such events that month. Following this startling testimony of how therapy is taking over our lives, he readably marshals a wide range of criticisms of how therapeutic thinking is influencing the wider culture.

At first glance the book's extensive referencing seems to support the idea that *Therapy Culture* is an academically rigorous treatise. However, on closer inspection, it becomes clear that most of the references are to newspaper articles or websites. For example, Furedi's intriguing claim that by 1995 nearly half the US population had experienced some kind of psychotherapeutic intervention and that estimates suggest the figure is now 80% comes from the *Montreal Gazette*. In the first chapter, out of nearly 100 references I could find fewer than five that appeared to be to peer reviewed academic journals.

Furedi accords to the preoccupations and contentions of the popular press the same status as one would give an academically rigorous gathering of data in a published study. To use journalism as a way of working out what is going on in society is a surprising strategy for anyone who straddles the worlds of both the media and academe, as Professor Furedi increasingly does. But he would probably soothingly argue that I am worrying too much and that therapy culture now means that I might even rashly claim to be traumatised by the experience of reading his book.

That does not mean that there aren't some significant ideas here. It is interesting to note that while liberal society is not convinced that it should persuade us to *believe* in anything, other than tolerance for other beliefs, it is now preoccupied with how we should feel. It is also noteworthy that Western governments keen on re-election have begun to focus on how to improve a sense of well-being in the electorate, which raises the issue of who should take responsibility for our emotions.

Doctors in general and psychiatrists in particular increasingly fear bureaucratic and public inquiries pointing the finger of blame if patients take their own lives or behave in some other way that might inflict suffering on others. Furedi is right that people nowadays seem to accept less responsibility for their feelings and instead increasingly load the burden on to professionals such as doctors. The medical profession will therefore welcome this searing analysis of the slippery slope towards a future when how patients feel, as well as their health, have become entirely our responsibility and not theirs.

It is only by taking responsibility for themselves, their beliefs, and their emotions that people become truly free. Exactly how we got to the stage where therapy can imprison rather than liberate is enigmatic, and Furedi performs a valuable service in charting this journey. But his polemic misses the undeniable fact that some therapy has helped some people. Furedi seems to reject the reality of the genuine suffering that therapists work to ameliorate.

Perhaps in future editions of *Therapy Culture* Furedi could acknowledge the growing work that "positive psychology" and other new fields are doing in pioneering resilience enhancement and self taught coping skills. But it is hard to imagine him doing this while he appears to reject any form of psychological thinking at all. If Furedi could embrace the fact that psychology is not synonymous with therapy, his work could become a more valuable resource for those wrestling with the genuine conundrum of whether to seek therapy or try the reliable alternatives that now exist.

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Items reviewed are rated on a 4 star scale (4=excellent)

NETLINES

● The UK based Drug Safety Research Unit is a charity concerned with detecting side effects associated with newly marketed drugs. It has a compact, informative, and user friendly website (www.dsru.org/), which, as well as explaining the role of the unit, includes a news section, a publications section, and a useful links page. There is a section aimed specifically at general practitioners and also one for patients, who are often overlooked in professional sites.

● Medical humour has always been distinctive and there have been thousands of medical gags in circulation for years. Now the jokes are online, as well as medical satire and animated cartoons. http://galaxy.einet.net/galaxy/Medicine/Humor/ is a collection of links to sites rich in medical humour. It provides rich pickings for updating joke inventories or for just keeping colleagues amused.

● Blogs or weblogs—online personal journals—are becoming increasingly popular. http://blacktriangle.org/blog/ concerns drugs and adverse reactions. As well as regular and informative diary entries, this clearly designed site has a good sprinkling of links, typical of a good blog. The 24 November entry included a link to an auction for an online community of UK pharmacists. There is a search facility and it is also possible to contact and read about the author.

● The European Helicobacter Study Group has produced a useful online resource (www.helicobacter.org). The home page contains a list of hypertext subject headings linking to various sections such as biographies of group members, expert advice on treatment (but be prepared to fill out a form), and guidelines. There is also a links page, which is a good introduction to the many helicobacter sites available. Although this site is aimed at the professional, it also offers a patient oriented section.

● Many doctors only vaguely remember their anatomy, but there is online help—after all, the web is an ideal medium for publishing an anatomy atlas. CyberAnatomy Tutorials from the University of Newcastle upon Tyne is such an online resource (http://anatome.ncl.ac.uk/tutorials/index.html). It uses simple interactivity to display many major anatomical systems on display. The graphics are of high quality and the anatomical structures are slickly labelled. There are also biographies of the various prosectors and an in-house search engine.

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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

ER blamed for nursing shortage

The top rated television show *ER*, now in its tenth season, is the target of a letter writing campaign by nurses who say that the show's depiction of them is demeaning. Such a negative portrayal, they say, is contributing to the critical shortage of nurses in the United States.

The show is wildly popular with audiences around the world. Twenty million US viewers alone tune in every week to watch, for example, patients with gunshot wounds or terminal cancer, or wealthy hypochondriacs pouring in through the doors of a level one trauma hospital in Chicago. The care of patients in *ER* always triggers ethical conundrums. Tempers flare. Doctors clash. In the end, the right thing is not always done.

The issues that the show tackles have long made it a target of advocacy groups. Anti-vaccination campaigners and advocates for blind people have protested about segments of *ER*. Now nurses are the ones who are angry, saying that they are being depicted as "handmaidens" to doctors. This, they claim, is contributing to the critical shortage of nurses in the United States.

Sandra Jacobs Summers, executive director of the Center for Nursing Advocacy, the Baltimore-based organisation that launched the letter writing campaign, says that *ER*'s portrayal of nurses is not only negative, it is inaccurate. "They have physicians doing nurses' work." Ms Summers says that doctors are shown performing almost all defibrillations, even though "99% of defibrillations are performed by nurses." She adds, "If viewers saw nurses doing defibrillations, they might realise that nurses have to understand complex rhythms, take serious action, and use autonomous thinking."

Diana Mason, editor in chief of the *American Journal of Nursing*, echoes Summers' concerns, saying that the show "is absolutely a problem." She is disturbed that in the show "every nurse considers going to medical school." But she says, "If you ask most nurses if they had a choice … they would choose to be nurses, so why are they portraying every nurse as a doctor wannabe?"

Dr Mason, who emphasises that nurses are not looking for "perfect" television images, says the character Hot Lips Hoolihan in the television series *M*A*S*H* was "a bit loony, but she was about excellence in care; she was in charge of nursing and she was respected."

She says, "We're in the middle of a nursing shortage that is a public health crisis." She points to studies, recently reviewed in an Institute of Medicine report, showing that the higher patient to nurse ratios associated with cuts are positively correlated with increased medical error and, in turn, increased morbidity and mortality.

GETTY IMAGES

Look who's doing the defibrillating

But others are not so convinced that *ER* portrays nurses negatively or that it plays a substantial role in the nursing shortage. Gabi Ford, an emergency nurse in Eugene, Oregon, says, "Overall the show has projected nurses in a very positive light." In an article published in June in *NurseWeek News*, author Bree LeMaire describes how several advanced-practice nurses are involved with the show. She concludes, "The technical directors of *ER* have a built-in respect and regard for nurses."

Some experts say that working conditions rather than television images are at the heart of the current nursing shortage. "Pay is always an issue," says Frank A Sloan, professor of economics at Duke University. "*ER* is probably 87th among the reasons—we had this problem back when television was black and white."

Professor Sloan says that as women have moved into areas that were previously closed to them and have gained degrees in subjects such as business administration and medicine, they no longer want to take jobs as nurses, which pay less and command less respect, even if undeservedly so. Some hospitals, he says, have job openings, but "they're not willing to pay what it will take to get [full time nurses] so they use travelling nurses and whatever else it takes."

But Diana Mason takes issue with Professor Sloan's assessment. "Hospitals do have money," she says. "Besides, there is data showing that if you staff properly, it will decrease length of stay, nurse turnover, and this reduces costs. It takes $60 000 to recruit a nurse. [Better staffing] reduces risk payouts as well." Dr Mason emphasises that "collaboration and communication" between doctors and nurses is a critical predictor of patient outcomes—something that she says is missing in *ER*.

Warner Brothers Television has issued a statement saying, "We are very proud of the award winning television drama series *ER*, which goes to great lengths to portray medical situations accurately."

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WEBSITE OF THE WEEK

Living organ donation Two letters in this week's *BMJ* present conflicting views of living liver donation (p 1287). In arguing in favour of donation, Roger Williams says that there is an "unacceptable" wait for cadaver organs and that the UK transplant rate is already one of the lowest in the West. Wherever there's a shortage, as there is of organs for transplant, there is scope for online information campaigns.

The US based Coalition on Donation explains that kidneys are the most common organ donated by living donors, while other organs that can be donated include partial liver, lung, and pancreas (www.shareyourlife.org/become_livingdonor.html). The site lists the advantages to the recipient of living donation, the risks, and the lifelong considerations of being a donor.

The US Living Organ Donor Network (www.lodn.org) allows information regarding living kidney donors to be placed, for the first time, in a common database "so medical professionals can collect the demographic and medical characteristics of these individuals." Most of the site is password protected, but there's a brief information page and online forum with personal stories.

Living Donors Online! (www.livingdonorsonline.org/) aims to be "the preeminent online community for living donors, potential donors, their families, and medical professionals." As well as general and organ-specific information, there is a Living Donor Hall of Fame and a buddies programme matching potential donors with those who have already donated.

The shortage of organs for transplant has also spawned sites of dubious ethical provenance. As the *Independent on Sunday* newspaper reported earlier this year, Liver4you.org claims to be able to provide transplant surgery in the Philippines in as little as 10 days, using cadaver and live donor organs. "Come to Manila and meet the doctor," the site urges, pointing out the cost of kidney surgery runs from $35 000 to $85 000 (£21 000; €30 000 to £50 000; €72 000) and liver surgery from $150 000 to $250 000, and that a flight with Korean Air or China Air would cost around $850. The site was originally highlighted by the charity Organs Watch (http://sunsite.berkeley.edu/biotech/organswatch/index.html), which monitors the international trade in illegal organs.

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PERSONAL VIEW

Who'd be a reformer?

Ten years ago I was not prepared for the critical letter from the president of my surgical association, after the publication of a *BMJ* editorial I had jointly written (1994;309:620-1) on surgical removal of third molars—one of the commonest operations. We said, on the basis of convincing evidence, that prophylactic removal should be abandoned. I had, apparently, been naive. He was certainly right in one respect: I had been naive enough to think that our conclusion—later reached by the National Institute for Clinical Excellence in its first technology appraisal—would, in the age of evidence based medicine, be welcomed.

The ensuing debate in the *BMJ*'s letters pages was polarised by the media. A *Times* article starkly contrasted our conclusion with the opposite view of a consultant colleague in my own department. The headline in the *Independent on Sunday*, "Millions wasted on wisdom teeth," spanned a whole page. This taught me something else: that professional and public controversy can be a powerful, even essential, component of reform. But public controversy needs a thick skin.

It is easier to engage in one controversy at a time; I am not sure I could have coped at the same time with the onslaught from the British glass industry that followed publication of our research finding that pub glasses were often used as weapons in assault and that toughened glasses were safer than non-toughened glasses (*BMJ* 1994;308:932). Before the UK glass industry switched to toughened pint glasses in 1997 I vividly remember picking up the office phone to hear the director of a glass company protesting that my research would put 500 of his employees out of work.

Researchers must weigh the cumulative evidence and select a suitable battleground if the evidence makes a strong case for reform. Real change, it seems, involves illumination by scores of professional and media searchlights and friendly as well as enemy fire. It helps, of course, to have allies—for example, in the Cochrane Collaboration and among clinical colleagues. The task of reform has been made easier by clinical governance, new national authorities, and a government intent on raising standards and making communities safer.

Other reforms I have been involved in relate to training and legislation. In the early 1990s a scarcity of potential senior lecturers in oral and maxillofacial surgery threatened the discipline. Survival demanded radical and concerted action by senior academics. The solution was a new specialist academic training programme, but it was only accepted and implemented after fierce debate. Now, not only have there been trainees in this programme in almost every UK university department but five have achieved chairs.

The only reform I have worked for that has not, so far, been characterised by controversy and antagonism at a personal level is the only one that has become statutory: the establishment of the NHS as a partner in community crime prevention. Evidence over several years showed that most violence resulting in treatment is not known about beyond the NHS. Here, the forum for debate was parliament, where a Home Office minister responsible for the Crime and Disorder Bill (1997) was persuaded that the NHS had an important role in the surveillance and prevention of violence. However, perhaps the lack of controversy is because few public health and emergency doctors and managers have yet to be engaged in implementation. Legislation is certainly not the end of reform.

> The evidence based reformer can still face isolation, ostracism, and cost

Forceful public argument does not fit comfortably with the way that academics present the research findings that are the foundation for reform. However, clinical academics are used to making definite clinical decisions. Medicine and dentistry have a distinct advantage in this respect over almost all other public services, such as education, the law, and policing, where the generation of new knowledge is not integrated with practice. But the evidence based reformer can still face isolation, ostracism, and cost. Presidents of associations who write letters criticising reformers are not likely to back them for distinction awards. In relation to the campaign for the NHS to help prevent violence a professor of criminology called me a moral entrepreneur, which made me feel like an evidence averse goody two shoes. Reform can be easier outside one's own professional group—though, like charity, it usually begins at home.

New values, circumstances, and evidence constantly challenge inertia, conformity, and commercial interests in practice and in industry. Reform may not be achieved immediately or completely. But without advocates it will never happen. I pay tribute to those who have expressed strong views and debated the issues of my own professional times: in the British Association of Oral and Maxillofacial Surgeons, the *BMJ*, the Home Office, the faculties of dental surgery, and the media. Without them there would have been no controversy—and no progress.

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SOUNDINGS

What does the patient want?

"What made you suspicious, Farrell?"

Holmes was a trifle unimaginative, but he was a stout fellow and well worth his keep, as the big problem with a meritocracy is that good servants are hard to find; when everybody's somebody, then nobody's anybody.

"It was the curious incident of the cough in the night," I said.

"But the patient did not cough in the night," said Holmes.

"Exactly," I said, "and that was the curious incident."

A symptom's absence may sometimes be as telling as its presence. Joe was an almost daily attender, could never leave without a prescription, and had as many symptoms as there are stars in the sky, so when he said he had yet another headache I was not overly concerned. He had nausea and vomiting, yet was the headache worse in the morning and on leaning forward? Of course. Had he double vision? No. And I heard a cock crow three times. For Joe to deny a symptom was as rare as somebody who declares war and actually takes part in it.

> His ears grew longer and even hairier

After 20 years in practice, I'm hard to shock, so I was only mildly surprised when his skin suddenly turned a bilious green, his ears grew longer and even hairier, and antennae sprouted from his head, all of which actually improved his appearance. "I am an emissary from the planet Zarg," he said, his voice sibilant and his breath pungent yet noxious, his forked tongue dripping acid saliva on my foot. "Our beloved Emperor Peebo has been most gravely ill for many years and I have long been seeking a physician both wise and intuitive who might provide a cure for this distressing malady. If you succeed you shall be deemed Lord of all Doctors in the Universe and our two peoples shall abide in everlasting friendship."

"What are his Majesty's symptoms?" I asked.

"He has a sore throat and has been bringing up horrible green phlegm."

"Gosh, Joe," I said, "the things you'll do to get an antibiotic."

Liam Farrell *general practitioner, Crossmaglen, County Armagh*